amount of funds that may be available to the State.

[71 FR 30290, May 26, 2006]

§ 403.504 Number and size of grants.

(a) *General.* For available grant funds, up to and including $10,000,000, grants will be made to States according to the terms and formula in paragraphs (b) and (c) of this section. For any available grant funds in excess of $10,000,000, distribution of grants will be at the discretion of CMS, and will be made according to criteria that CMS will communicate to the States via grant solicitation. CMS will provide information to each State as to what must be included in the application for grant funds. CMS awards the following type of grants:

(1) New program grants.

(2) Existing program enhancement grants.

(b) *Grant award.* Subject to the availability of funds, each eligible State that submits an acceptable application receives a grant that includes a fixed amount (minimum funding level) and a variable amount.

(1) A fixed portion is awarded to States in the following amounts:

(i) Each of the 50 States, $75,000.

(ii) The District of Columbia, $75,000.

(iii) Puerto Rico, $75,000.

(iv) American Samoa, $25,000.

(v) Guam, $25,000.

(vi) The Virgin Islands, $25,000.

(2) A variable portion, which is based on the number and location of Medicare beneficiaries residing in the State is awarded to each State. The variable amount a particular State receives is determined as set forth in paragraph (c) of this section.

(c) *Calculation of variable portion of the grant.* (1) CMS bases the variable portion of the grant on—

(i) The amount of available funds, and

(ii) A comparison of each State with the average of all of the States (except the State being compared) with respect to three factors that relate to the size of the State's Medicare population and where that population resides.

(2) The factors CMS uses to compare States' Medicare populations comprise separate components of the variable amount. These factors, and the extent to which they each contribute to the variable amount, are as follows:

(i) Approximately 75 percent of the variable amount is based on the number of Medicare beneficiaries living in the State as a percentage of all Medicare beneficiaries nationwide.

(ii) Approximately 10 percent of the variable amount is based on the percentage of the State's total population who are Medicare beneficiaries.

(iii) Approximately 15 percent of the variable amount is based on the percentage of the State's Medicare beneficiaries that reside in rural areas (''rural areas'' are defined as all areas not included within a Metropolitan Statistical Area).

(3) Based on the foregoing four factors (that is, the amount of available funds and the three comparative factors), CMS determines a variable rate for each participating State for each grant period.

(d) *Submission of revised budget.* A State that receives an amount of grant funds under this subpart that differs from the amount requested in the budget submitted with its application must submit a revised budget to CMS, along with its acceptance of the grant award, that reflects the amount awarded.

[59 FR 51128, Oct. 7, 1994, as amended at 65 FR 34986, June 1, 2000; 71 FR 30290, May 26, 2006]

§ 403.508 Limitations.

(a) *Use of grants.* Except as specified in paragraph (b) of this section, and in the terms and conditions in the notice of grant award, a State that receives a grant under this subpart may use the grant for any reasonable expenses for planning, developing, implementing, and/or operating the program for which the grant is made as described in the solicitation for application for the grant.

(b) *Maintenance of effort.* A State that receives a grant to supplement an existing program (that is, an existing program enhancement grant)—

(1) Must not use the grant to supplant funds for activities that were conducted immediately preceding the date of the initial award of a grant made under this subpart and funded through other sources (including in-kind contributions).

(2) Must maintain the activities of the program at least at the level that those activities were conducted immediately preceding the initial award of a grant made under this subpart.

[59 FR 51128, Oct. 7, 1994, as amended at 65 FR 34986, June 1, 2000; 71 FR 30290, May 26, 2006]

§ 403.510 Reporting requirements.

A State that receives a grant under this subpart must submit at least one annual report to CMS and any additional reports as CMS may prescribe in the notice of grant award. CMS advises the State of the requirements concerning the frequency, timing, and contents of reports in the notice of grant award that it sends to the State.

§ 403.512 Administration.

(a) *General.* Administration of grants will be in accordance with the provisions of this subpart, 45 CFR part 92 (''Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments''), 45 CFR 74.4, the terms of the solicitation, and the terms of the notice of grant award. Except for the minimum funding levels established by § 403.504(b)(1), in the event of conflict between a provision of the notice of grant award, any provision of the solicitation, or of any regulation enumerated in 45 CFR 74.4 or in part 92, the terms of the notice of grant award control.

(b) *Notice.* CMS provides notice to each applicant regarding CMS's decision on an application for grant funding under § 403.504.

(c) *Appeal.* Any applicant for a grant under this subpart has the right to appeal CMS's determination regarding its application. Appeal procedures are governed by the regulations at 45 CFR part 16 (Procedures of the Departmental Grant Appeals Board).

Subpart F [Reserved]

Subpart G—Religious Nonmedical Health Care Institutions—Benefits, Conditions of Participation, and Payment

SOURCE: 64 FR 67047, Nov. 30, 1999, unless otherwise noted.

§ 403.700 Basis and purpose.

This subpart implements sections 1821; 1861(e), (y), and (ss); 1869; and 1878 of the Act regarding Medicare payment for inpatient hospital or posthospital extended care services furnished to eligible beneficiaries in religious nonmedical health care institutions.

§ 403.702 Definitions and terms.

For purposes of this subpart, the following definitions and terms apply:

Election means a written statement signed by the beneficiary or the beneficiary's legal representative indicating the beneficiary's choice to receive nonmedical care or treatment for religious reasons.

Excepted medical care means medical care that is received involuntarily or required under Federal, State, or local laws.

FFY stands for Federal fiscal year.

Medical care or treatment means health care furnished by or under the direction of a licensed physician that can involve diagnosing, treating, or preventing disease and other damage to the mind and body. It may involve the use of pharmaceuticals, diet, exercise, surgical intervention, and technical procedures.

Nonexcepted medical care means medical care (other than excepted medical care) that is sought by or for a beneficiary who has elected religious nonmedical health care institution services.

Religious nonmedical care or religious method of healing means health care furnished under established religious tenets that prohibit conventional or unconventional medical care for the treatment of a beneficiary, and the sole reliance on these religious tenets to fulfill a beneficiary's total health care needs.

RNHCI stands for ''religious nonmedical health care institution,'' as defined in section 1861(ss)(1) of the Act.

Religious nonmedical nursing personnel means individuals who are grounded in the religious beliefs of the RNHCI, trained and experienced in the principles of nonmedical care, and formally recognized as competent in the administration of care within their religious nonmedical health care group.